



Healthcare Analytics in Navy Medicine

Perspectives and Methods for Decision-Making

FOCUS ON OBSTETRICAL CARE AND QUALITY

Standardizing Processes to Improve Quality

In today's military, women are serving in increasing numbers and roles, and the obstetrical care of our service members and dependent family members comprises a large portion of enterprise operations. Additionally, hospitals and health care systems, including the Military Health System (MHS), are responding to a growing recognition of the need for improvement in quality and patient safety and the elimination of adverse risks to pregnant women and their babies. This article focuses on current efforts to improve obstetrical care quality through standardization of processes and to increase quality and safety transparency.

Of the approximately four million women who give birth each year in the U.S., nearly 13 percent experience one or more major complications. There is also growing evidence that the rate of major obstetrical complications varies markedly across U.S. hospitals.¹ From a policy and operations perspective, it is crucial to standardize best practices and develop quality measurement and reporting strategies that focus on improving obstetrical outcomes. Additionally, reducing adverse outcomes during and following pregnancy insures active duty women are ready to return to duty in a timely manner and able to take care of their family members. Improving outcomes in obstetrics is a long and complicated journey, but the MHS has been focused on two critical steps in quality improvement: 1) reduce variability in clinical processes of care, and 2) develop a data Infrastructure for perinatal care quality and make the information accessible. The sections below include examples of some of

the enterprise-wide and Navy-specific efforts to ensure adherence to evidence-based care processes and expand public reporting of hospital-level data.

Improving Quality and Safety Through Enterprise-wide Standardization

For many reasons, women often consider giving birth at home or at a birthing center rather than in a hospital, and the number of out-of-hospital births is increasing in the U.S. While home birth is a safe option for some but not advised for others, the growing numbers of home births have continuously raised questions of safety, midwife licensing and training, communication between midwives and doctors, and hospital transfers should any problems emerge. To address this issue, Navy Medicine recently provided guidance for providers on how to counsel service members or beneficiaries who wish to deliver in a non-medical setting such as home births and free-standing birthing centers.² TRICARE will cover births in non-medical settings under certain circumstances. Per the instruction, an active duty service member may deliver in a non-clinical setting provided they have been counseled by a military treatment facility (MTF) provider who delivers obstetric care. This counseling includes a discussion of the risks, benefits and alternatives, as well as the cost implications, of delivery in an alternate setting. Furthermore, TRICARE will cover delivery at various locations, including home births and birthing centers, provided the care is delivered by Obstetrician/Gynecologists, Certified Nurse Midwives (CNMs),

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The content of this publication does not represent the official view of the US Navy Bureau of Medicine and Surgery, the United States Navy, the United States Department of Defense or the United States Government.

1 Glance LG et al. Rates of major obstetrical complications vary almost fivefold among US hospitals. *Health Aff.* 2014 Aug;33(8):1330-6. doi: 10.1377/hlthaff.2013.1359.

2 OPNAVINST 6000.1D, "Navy Guidelines Concerning Pregnancy and Parenthood", section 3a, "Provisions of healthcare".



Family Medicine Physicians, General Practitioners, or Primary Care Managers. TRICARE does not cover lay midwives, certified professional midwives or certified midwives, or non-medical support during labor such as doulas or labor coaches. The guidance also reviews when home births are not recommended for certain medical conditions and circumstances.

Navy Medicine is also working on service-wide implementation of a postpartum hemorrhage bundle to prevent the leading cause of maternal death worldwide. Postpartum hemorrhage is defined as the cumulative blood loss equal to or greater than 1000mL or blood loss accompanied by signs/symptoms of hypovolemia within 24 hours following the birth process. Originally introduced in MTFs in the Navy Medicine West Command, the purpose of this bundle is to create a rapid coordinated response for postpartum hemorrhage. The postpartum hemorrhage bundle includes several key components: 1) Staff and facility readiness, which includes a hemorrhage cart with needed supplies and drugs, as well as transfusion protocols, and staff training; 2) recognition and prevention of hemorrhage risk, signs, and symptoms; 3) rapid response checklists and support; and 4) post-event reporting, review, and analysis. The goal of this bundle is to reduce the variability of event response among facilities and optimize patient outcomes for every delivery.

The Defense Health Agency is also currently working to standardized newborn naming protocols across MHS direct care in an effort to reduce patient safety errors caused by infant misidentification. This effort coincides with recent two-factor identification requirements for newborn naming by The Joint Commission (TJC). Draft policy recommendations that aim to standardize distinct naming conventions for infants and meet the new TJC standards include: 1) standardizing the content of legible hand-written four-part couplet identification bands for mom and baby; 2) standardizing the placement of the hand-written four-part couplet identification bands; and 3) requiring every infant to have a digital identification band (the 5th band) that contains a unique identifier for infant point of care testing, procedures, and diagnostics.

There are also ongoing efforts to standardize guidance and checklists across MTFs for trial of labor after Cesarean (TOLAC) for women who have had a previous C-section and wish to deliver vaginally in subsequent pregnancies. Similarly, Navy Medicine is also working with N1, Navy's office of Inclusion and Diversity, to standardize

guidance for postpartum care for Sailors who may have suffered a perinatal loss or miscarriage. .

Improving Quality Transparency

Following the Secretary of Defense's MHS Review in 2014 and additional measures passed by Congress in the Fiscal Year 2016 National Defense Authorization Act, there have been ongoing efforts to make quality and safety information available to the public to increase transparency and accountability. This hospital-level public reporting includes quality and patient safety measures related to perinatal care. Currently, each military hospital and clinic now has a landing page on the [MHS Quality, Patient Safety, and Access Information](#) site where patients can access perinatal data in one place. The reported measures include TJC's ORYX Perinatal Care core measures for discharges through the end of calendar year 2017. Some individual facilities, such as the Walter Reed National Military Medical Center (WRNMMC) online [Quality and Safety Reports](#), have enhanced perinatal care quality reporting with additional graphics and measure information. The goal is to expand reporting of MHS perinatal metrics beyond the ORYX Perinatal Care core measures to include other outcomes, such as labor induction rates, TOLAC rates, vaginal birth after cesarean (VBAC) rates, and postpartum depression screening.

As Navy Medicine continues its goal of delivering the safest and highest quality obstetric care, additional process standardization efforts and increased transparency will be pursued.

Information for this article was constructed by Allison Russo (Kennell and Associates) from an interview with CDR Shannon Lamb, Office of Women's Health BUMED.



SKILLS AND METHODS

– GLOBAL BILLING FOR OBSTETRICAL CARE

This section provides an overview of global billing in purchased care claims data and its impact on the analysis of obstetrical care. Considerations for disassembling global bills are discussed.

Many analysts are often inclined to report cost and workload data segregated by whether the care was inpatient or outpatient. This segregation is usually indistinguishable in purchased care claims data for many professional services, including the obstetrics product line, where global payment rules obscure that distinction. When measuring patient access and the quality of maternity care, global billing can make it difficult to determine the number of prenatal and postpartum visits a mother received over the course of her maternity period.

Purchased care providers who seek reimbursement from TRICARE are generally required to follow HIPAA's rules for the submission of claims data. These rules include the concept of global payments for most procedural care. A global payment is one where the CPT code, relative value units (RVUs), and payment represent the complete package of routine services, including expected routine pre-procedure and follow-up visits. When providers submit global bills, they are generally not allowed to submit separate claims for the pre-procedure and follow-up visits related to the principal procedure. Moreover, when the principal procedure being billed is an inpatient procedure, this global billing practice blurs the line between inpatient and outpatient services.

Obstetrics is a product line that is particularly affected by global billing. Unlike most types of procedures, deliveries have many pre-procedure visits (roughly 12 prenatal visits). When a provider submits a global obstetrical bill, the dates of care represent the date of the delivery and inpatient stay. Moreover, the place of service is indicated as inpatient, because the principal procedure (i.e., the delivery) was inpatient. However, since the global bill represents the entire package of obstetrical care, the RVUs and costs on the record actually represent both inpatient and outpatient care throughout the maternity period. Also, "visits" are not counted for global codes because of the inpatient place of service used on the claims record.

As a result, analysts cannot simply count obstetrical visits, RVUs, and costs in purchased care claims data using the place of service, as the results would be misleading.

Rather, the data must be disassembled to properly make the distinction. There is no perfect way to disassemble global billing records to allow discrete reporting of inpatient and outpatient care. Assumptions must be made based on "business as usual". That is, it is assumed the patient will have scheduled visits one per month during the first 28 weeks of pregnancy, two per month in weeks 28 through 36, and weekly visits in the last four weeks, for a total of 12 prenatal visits (assuming that the mother would not show up for prenatal care during the first month of pregnancy when she might not yet know of her condition). Normal postpartum care could also be assumed (usually one visit for a vaginal delivery and two visits for a C-section), for a total of 12-13 outpatient visits associated with each global CPT code reported.

To estimate outpatient and inpatient RVUs, additional codes and values may be helpful. Using the CMS Physician Fee Schedule [search](#), weights can be obtained for each CPT procedure code. A selection of relevant codes and their work RVU values are listed in Figures 1-3.

Using the global vaginal delivery CPT code (59400) as an example, the total RVUs (20.14) represents the full package of prenatal visits, delivery, and postpartum care during the entire maternity period (Figure 1). Figure 2 displays RVU values for delivery only CPT codes and low-intensity rounds. Any inpatient RVUs would need to be reflective of both the vaginal delivery itself and the inpatient low-intensity rounds visits that are associated with it. Since the average length of stay for an uncomplicated delivery is about two days, assume one rounds visit (no rounds visit while the baby is actually being delivered). As shown in Figure 3, adding the vaginal delivery only RVUs (CPT code 59409) to the RVUs for one low-intensity rounds visit (CPT code 99221) results in a total estimated inpatient RVU of 6.45 (5.69 + 0.76). The remainder of the global vaginal RVU (13.69) would be assumed to be associated with outpatient care.

Finally, now that RVUs have been estimated for inpatient and outpatient professional services, payment and billing amounts can also be apportioned on the basis of RVUs. For example, if the amount paid for the professional fee associated with a vaginal delivery was \$2,157, then the percentages that were estimated for inpatient and outpatient RVUs could be applied to separate inpatient and outpatient costs as well.



Figure 1. Notional TRICARE Data

CPT Code	Description	Begin Date	End Date	Place of Service	Total RVU ³	Number of Visits
59400	Vaginal delivery, full package	2/1/2018	2/2/2018	Inpatient	20.14	0
59510	C-Section, full package	2/1/2018	2/4/2011	Inpatient	21.83	0

Figure 2. RVU Table

CPT Code	Description	Total RVU
59400	Vaginal delivery, full package	20.14
59510	C-Section, full package	21.83
59409	Vaginal delivery only	5.69
59514	C-Section, delivery only	6.32
99221	Low intensity rounds	0.76

Figure 3. Disassembled Global Bill

CPT Code	Description	Total RVU	% Total	Amount Paid
59400	Vaginal delivery, full package	20.14	100%	\$ 2,157
59409	Vaginal delivery only	5.69	28%	\$ 604
99211	Low intensity rounds	0.76	4%	\$ 86
IP Total	Total inpatient professional	6.45	32%	\$ 690
OP Total	Total ambulatory professional	13.69	68%	\$ 1,467

DATA AND INFORMATION SYSTEMS

– PERINATAL CARE CORE MEASURES

This section provides an overview of the six Perinatal Care Core Measures used by The Joint Commission to manage and monitor aspects of perinatal care that are critical to improving and maintaining the health of newborns and their mothers.

The Joint Commission is an independent, not-for-profit organization that evaluates and accredits nearly 21,000 health care organizations in the U.S., as well as organizations in countries worldwide. The Joint Commission accredits organizations across the spectrum of care

including hospitals, skilled nursing facilities, home care, and ambulatory care. The organization also offers Advanced Certifications for specialty areas. The Perinatal Care Certification focuses on achieving integrated, coordinated, patient-centered care for clinically uncomplicated pregnancies and births. The certification program uses standards and guidelines related to the management of prenatal through postpartum care and to the mothers' and newborns' risk for adverse events. There is also a requirement to monitor and report related perinatal care core performance measures.

The Joint Commission's Perinatal Care (PC) measures were originally comprised of five measures. Hospitals

³ "Facility Practice Expense" RVUs were used to calculate total RVUs since deliveries are usually inpatient in nature.



began collecting data for the PC measures beginning with April 1, 2010 discharges. Effective January 1, 2019, The Joint Commission will now require the collection of six measures. All of the PC measures are chart-abstracted measures and require the use of The Joint Commission's ORYX chart-based vendor. For Perinatal Certification, there are no minimum births required for reporting, and all participants must report all six PC measures, which include:

- PC-01 Elective Delivery – Elective vaginal deliveries or elective Cesarean births at ≥ 37 and < 39 weeks of gestation completed.
- PC-02 Cesarean Birth – Nulliparous women with a term, singleton baby in a vertex position delivered by Cesarean birth.
- PC-03 Antenatal Steroids – Patients at risk of preterm delivery at ≥ 24 and < 34 weeks gestation receiving antenatal steroids prior to delivering preterm newborns.
- PC-04 Health Care-Associated Bloodstream Infections in Newborns – Staphylococcal and gram-negative septicemias or bacteremias in high-risk newborns.
- PC-05 Exclusive Breast Milk Feeding – Exclusive breast milk feeding during the newborn's entire hospitalization.
- PC-06 Unexpected Complications in Term Newborns – The percent of infants with unexpected newborn complications among full-term newborns with no preexisting conditions. Severe complications include neonatal death, transfer, severe birth injuries, neurologic damage, or severe respiratory and infectious complications. Moderate complications include diagnoses or procedures that raise concern but at a lower level than severe.

Three of these measures relate to the mother's care (PC-01, PC-02, and PC-03). The remaining three relate to the newborn's care (PC-04, PC-05, PC-06). Additional information about each PC measure, as well as detailed measure specifications, can be found on The Joint Commissions [website](#).

NEW KNOWLEDGE

– NOTED PUBLICATIONS

The articles below explore the role of race in perinatal safety and outcomes. According to the Centers for Disease Control and Prevention, black women in the U.S. die at a rate of 43.3 per 100,000 live births, compared to only 12.7 deaths per 100,000 live births for white women. Similarly in 2015, black infants died at a rate of more than two times the rate for white infants. Experts believe persistent poverty, chronic stress, and lack of access to health care providers are some of the factors that explain persistent racial disparities in these perinatal outcomes.

Adverse Birth Outcomes in African American Women: the Social Context of Persistent Reproductive Disadvantage.

Dominguez TP. Soc Work Public Health. 2011;26(1):3-16.

African Americans have the highest rates of infant mortality and adverse birth outcomes of all major racial/ethnic groups in the United States. The long-standing nature of this disparity suggests the need to shift epidemiologic focus from individual-level risk factors to the larger social forces that shape disease risk in populations. In this article, the African American reproductive disadvantage is discussed within the context of American race relations. The review of the literature focuses on racism as a social determinant of race-based disparities in adverse birth outcomes with specific attention to the viability of genetic explanations, the role of socioeconomic factors, the multidimensional nature of racism, and the stress-induced physiologic pathways by which racism may negatively affect pregnancy. Implications for social work research and practice also are discussed.

Learn more at <https://www.ncbi.nlm.nih.gov/pubmed/21213184>.

Blog: How Does Race Impact Childbirth Outcomes?

Nursing@Georgetown's Online FNP Program, February 5, 2018.

This blog post from the Georgetown University Nursing Program summarizes the existing racial disparities between infant and mortality outcomes, noting the lack of change despite national and local efforts to develop program interventions that focus on these deficits. This summary also includes a discussion of the role of chronic toxic stress on a pregnant woman's body, which is a key risk factor for early labor and other poor birth outcomes.



Finally, there is a discussion of possible solutions, including expanding diversity in the nursing and midwifery provider field, which may improve patient and provider communication and improve health equity.

Learn more at <https://online.nursing.georgetown.edu/blog/race-disparities-maternal-infant-outcomes/>.

Lost Mothers: Maternal Care and Preventable Births

ProPublica, 2017-2019.

This award-winning collection of radio pieces, articles, and databases illuminates the maternal mortality crisis in the United States. This multimedia project includes narratives of mothers; data analysis that explains the greater risks faced by African-American mothers; and a comparison to international health systems that have expanded monitoring and review requirements to reduce maternal mortality. Citing “Lost Mothers,” state and local lawmakers around the country have adopted a flurry of bills aimed at reforming how maternal deaths are identified and investigated.

Learn more at <https://www.propublica.org/series/lost-mothers>.

TIPS AND TRICKS

– ANALYSIS DOCUMENTATION IN M2

Documentation is a vital part of any analysis and should include information about the data sources, methodology, assumptions, and limitations. SAP Business Objects (BOXI), the software that operates M2, has numerous built in features that enable users to easily document their work in M2. This article will focus on documentation features available through BOXI, where to find them in BCS 4.2, and how they can be used for documentation with information from the M2 Data Status table.

Pre-Defined Cells in M2

M2 reports have a number of pre-defined cells that users can drag into their reports and that will update as users refresh data or change their tables, making any updates to documentation automatic. In BCS 4.2, the pre-defined cells are located under the ‘Report Elements’ ribbon and ‘Cell’ sub-ribbon (Figure 4). Most of the pre-defined cells are self-explanatory and provide clear labeling information (e.g., ‘Document Name’).

Figure 4. Pre-Defined Reporting Cells in M2

The screenshot displays the SAP Business Objects (BOXI) interface. The top ribbon includes 'Report Elements', 'Formatting', 'Data Access', 'Analysis', and 'Page Setup'. The 'Report Elements' ribbon is active, showing a 'Cell' sub-ribbon with a 'Pre-Defined' dropdown menu. The menu lists various pre-defined cells: Comment, Document Name, Last Refresh Date, Drill Filter, Query Summary, Prompt, Report Filter Summary, Page number, Page Number/Total Pages, and Total Number of Pages. The background shows a report titled 'CAPER' with a table of data. The table has columns: Tmt DMIS ID Name, Tmt Parent DMIS ID, Tmt DMIS ID, Tmt Parent DMIS ID, and Compliance. The data rows show various medical procedures and their associated IDs and compliance status.

Tmt DMIS ID Name	Tmt Parent DMIS ID	Tmt DMIS ID	Tmt Parent DMIS ID	Compliance
AF-C-1st SPCL OP: 7139		7139	AF-C-1st SPCL OP: I	
2015 AF-C-1st SPCL OP: 7139		7139	AF-C-1st SPCL OP: R	
2015 AF-H-96th MED GR 0042		0042	AF-H-96th MED GR I	
2015 AF-H-96th MED GR 0042		0042	AF-H-96th MED GR R	
2015 AF-LN-1st SPCL OP: 7139		5595	AF-C-1st SPCL OP: R	
2015 AF-LN-SPCL OPS / 0042		5592	AF-H-96th MED GR R	
2015 AF-LS-ARNOLD EN 0042		7079	AF-H-96th MED GR R	
2015 ERS-USAF-EMER 0042		5419	AF-H-96th MED GR R	
2015 ERS-USAF-FT WAL 0042		5475	AF-H-96th MED GR I	
2015 ERS-USAF-FT WAL 0042		5475	AF-H-96th MED GR R	



On pre-defined cell, the “Query Summary”, is a much more comprehensive feature, as it provides a description of the query panel (e.g., universe, result objects, and filters), the date and time the query was run, and the number of rows retrieved (Figure 5). The Query Summary is a useful documentation reporting cell and will update every time the query or queries in the report are rerun. For those users who just use M2 to extract data and perform all data manipulation and analysis in Excel, the Query Summary will be saved as a cell in Excel if it is inserted into the report. To insert any of the pre-defined cells into the report, select the desired option (e.g. Query Summary), and click in the white space of any tab in the report. The Query Summary does not include information on the class (e.g., CAPER Detail), but it does include the ‘Query Name’ and re-naming the query panel tab from Query 1 to the data source (e.g., TRICARE Rel Detail) will carry the documentation through to the report or Excel.

For those users, who prefer to do their analyses or tabulations in the M2 report and then export to Excel,

the “Report Filter Summary” pre-defined cell is also an easy way to document each table or chart in the M2 report. The Report Filter Summary will update as changes are made to individual tables, specifying how the table or chart was filtered, which is useful if the filtered variable does not appear in the table.

M2 Data Status Table

M2 users should also document the status of the data used in their analysis as of the date the query was run. An easy way to do that is through the M2 Data Status Table, which is available in both MHS Mart and Restricted universes. To add an M2 Data Status table to a report, select the ‘Edit Data Provider’ icon under the ‘File’ ribbon, and select ‘Add Query’ and the appropriate universe. The M2 Data Status table only contains nine variables, so just select the folder and drag it into the results objects. Then, select the down arrow next to ‘Run Queries’, and select the newly added query. Figure 6 contains the TRICARE Relationship Detail class rows from the M2 Data Status table that would accompany the above Query Summary.

Figure 5. Example of a Pre-Defined Reporting Cell – Query Summary

```
*** Query Name:Query 1 ***

** Query Properties:
  Universe:MHS MART (M2)
  Last Refresh Date:9/11/17 10:28 AM
  Last Execution Duration: 30
  Number of rows: 23
  Retrieve Duplicate Row: ON

** Query Definition:
  Result Objects: FY, FM, Enrollee Count
  Filters (    FY Greater than or Equal to 2,016
             AND Enrollment Site MSMA In List 11e
             )
```

Figure 6. M2 Data Status Table – TRICARE Relationship Detail

FY	Object Class	Reported As Of	Forecast Update	Available Date	Reported Date Range	Comment
2012	TRICARE Relationship Detail	10/12/15		11/25/16	Oct 11 - Sep 12	Risk adjustment Reprocessing
2013	TRICARE Relationship Detail	8/7/15		11/25/16	Oct 12 - Sep 13	Risk adjustment Reprocessing
2014	TRICARE Relationship Detail	9/1/14		11/21/16	Oct 13 - Sep 14	Risk adjustment Reprocessing
2015	TRICARE Relationship Detail	10/1/16		11/17/16	Oct 14 - Sep 15	Risk adjustment Reprocessing
2016	TRICARE Relationship Detail	9/1/16		3/24/17	Oct 15 - Sep 16	Walkback Processing
2017	TRICARE Relationship Detail	8/1/17	09/21/2017	8/30/17	Oct 16 - Aug 17	Walkback Data



For each FY of the TRICARE Relationship Detail file, the M2 Data Status Table includes: Reported As of Date, Forecast Update, Available Date, Reported Date Range, and any important comments. The Forecast Update informs the user the approximate date of the next update for each fiscal year. If the forecast update is within the next day or two, the user can decide whether or not to rerun the related query if having the most up-to-date information is a high priority.

The pre-defined cells, such as the Query Summary, and the M2 Data Status table allow M2 users to easily document their queries and address most data inconsistencies when comparing their analyses to those of other users. These documentation tools will also help determine if their analyses were impacted by time-specific data issues.

KNOWLEDGE SOURCES

— WISDOM TRAINING OPPORTUNITIES

The WISDOM course provides guidance for MHS managers, data analysts, and policy makers in the use of MHS data in support of operational questions, management decisions, and corporate goals. Using a mix of instructive briefings and hands-on exercises, WISDOM strives to provide analysts and decision-makers with the tools needed to support data-driven analysis and decision-making—keys to successful organizational performance. WISDOM is the educational vehicle that can translate the widespread availability of corporate data through the MHS Management Analysis and Reporting Tool (M2) into improved MHS operations.

Working Information Systems to Determine Optimal Management (WISDOM)—

The WISDOM course provides full instruction on the use of Business Objects and focused instruction on exploiting Microsoft Excel for analysis purposes. WISDOM also provides both an overview of different types of business and information systems used by the MHS (to include information systems, operational systems, corporate data warehouses and data marts), and specific detail on available data coming from those sources and accessible through the M2 data mart.

WISDOM participation is limited to individuals that currently have an M2 account and confirmed registration for the course. WISDOM is a 5-day class, held from Monday to Friday. Specific dates for FY 2019 WISDOM classes are noted below::

- Reston, VA – December 10-14, 2018
- San Antonio, TX – March 4-8, 2019
- San Antonio, TX – April 8-12, 2019
- Reston, VA – June 10-14, 2019
- Reston, VA – July 15-19, 2019
- San Antonio, TX – September 16-20, 2019

The WISDOM schedule and additional information about course requirements are available online at <http://www.health.mil/Military-Health-Topics/Technology/WISDOM-Training/Course-schedule>. For questions regarding the WISDOM course or to register, please send an email to DHA NCR Decision Support List at dha.ncr.dec-support.list.dha-dec-sup-wisdom@mail.mil. Please note that the course also offers Continuing Medical Education (CME) credits.

In addition to the WISDOM in-class course, monthly one-hour Defense Collaboration Services (DCS) sessions are presented on various subjects. M2 blaster messages are sent out to all M2 users for each session. All DCS sessions are presented twice to accommodate a variety of time zones. Recordings of the WISDOM webinars are available on milTube at [milSuite](https://www.milSuite.com); search for ‘WISDOM Webinar’.



IN THE NEXT ISSUE

The next issue of *Healthcare Analytics in Navy Medicine* will focus on pain management. The issue will discuss pain management policy and practice in the MHS, as well as considerations for the costs and quality of the services delivered in both the MTFs and purchased care. Additionally, data sources and data issues critical to the analysis of pain management services will be discussed.

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